STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003776	A. BUILDING: _____ B. WING _____	02/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IU HEALTH WEST HOSPITAL	1111 N RONALD REAGAN PKWY AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS Surveyor: 33212 Facility Number: 003776 Type of Survey: State Licensure Off Site JCAHO Accreditation Survey Date of JCAHO On Site Survey - Hospital full survey 2/18-21/2014 Date of ISDH off site review - 8/5/2014 Reviewer/Surveyor -Nancy Otten, RN, PHNS Based on review of the 2/21/2014 JCAHO Accreditation Survey Report, it has been determined that Indiana University Health West Hospital meets the requirements for Hospital Licensure in Indiana for2014.	S 000		